

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
Washington, D.C.

Thursday, March 21, 2002
10:10 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
BEATRICE S. BRAUN, M.D.
AUTRY O.V. "PETE" DeBUSK
ALLEN FEEZOR
FLOYD D. LOOP, M.D.
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA ITEM: Public Comment

MR. HACKBARTH: We will have a brief public comment period. Same ground rules; i.e., if one of the preceding commenters has already made your point, please don't reiterate it; try to make room for other folks. And if any given comment runs on too long, due to the late hour, which I apologize for, but in view of the late hour I'm going to urge the speaker along.

MR. WEBB: Mr. Chairman, commissioners, you have had a very long day and I will be as succinct as I possibly can be. I am Ed Webb, director of professional and government affairs for the American College of Clinical Pharmacy. I want to express our appreciation for the positive comments that arose during the discussion on the issue of extending provider recognition to pharmacists in the form of collaborative drug therapy management. I would just like to make several brief comments.

First, to say that before my career epiphany 15 years ago to come to Washington and work on these issues I was in fact a practicing clinical pharmacist in pediatrics and neonatology in the state of North Carolina, so I do have some personal experience in this regard from which I speak. So I just wanted to share some thoughts with you.

With regard to the issue of prematurity of the issue, and not just from the perspective of a neonatal clinical pharmacist but the prematurity of the issue of provider status, we would suggest to you that perhaps in the context of the smart pharmacy benefit discussion that you had earlier this morning that establishment of this kind of a benefit prior to the time of the government beginning to pay for the prescription drug product might in fact provide a quality infrastructure support for the expansion of a drug benefit at some later time.

As you mentioned, currently Medicare pays -- most Medicare beneficiaries have some coverage for their product-based services but not for the clinical care that they might need to use those products more effectively. This is a policy that can begin -- using this approach could begin to address the issue of quality and integrated health care delivery systems that have been reported in the Institute of Medicine report.

There were questions about the models and how this would be done. There's a rich set of models out there in the 33 or 34 states. This is how clinical pharmacists practice in the VA. This is how clinical pharmacists practice in the Indian Health Service, and we think there are a rich set of models for the Commission to look at and we'll be happy to work with the Commission to look at those, as well as cost estimates.

Our organization, collaboratively with two or three other pharmacy organizations has commissioned a private consultant to do an economic CBO-like analysis of the provisions of one or more of these models. It should be available toward the end of this month and we'd be more than happy to share that with the Commission staff to deal with that.

Finally, we'd just say that we are available to work with the Commission staff on an ongoing basis and look forward to the opportunity to do that, and appreciate all the time that you spent on the issue today. Thank you very much.

DR. LYNN: Hi, I'm Joanne Lynn. I'm the director of the Rand Center to Improve Care of the Dying and of Americans for Better Care of the Dying. But I'm speaking on behalf of neither at this point, but more as a hospice and long term care physician who's done an awful lot of research in hospice care. Incidentally, I'm the PI on the project that Chris Hogan was working on, and we could actually run the data to answer the questions that were raised if you want them done.

But the main thing I wanted to raise was whether the Congress' question with regard to hospice had to do with whether hospice as a program as it was established in 1983 was being run exactly correctly, and whether rural people had the same access? Or is it at least possible that the question was whether people coming to the end of life are getting the benefits of hospice care in some reasonably fair way?

The questions are quite different. It would be like asking, do people have access to a transplant surgeon, rather than, do people get the transplantations they need? You may well have -- people have equitable access to a transplant surgeon and yet have evidence that there would be substantial gaps in the actual availability of transplantation. I think if you used any similar analogy with hospice care, there certainly has been pretty good documentation that care of people coming to the end of life with serious chronic illness are not getting very good care.

To the extent that the question about hospice has to do with whether people are getting good care it seems that it is not completely answered by the question of whether hospice programs are growing and whether they can manage to stay afloat with the current reimbursement. But that the question would have to be something much more of whether there is still an enormous gap in the needs of Medicare beneficiaries.

I know that the Commission can hardly take that up before an April deadline, but it seems that that really is the question underlying this. To the extent that hospice was meant to cover some of that need and some of that gap, it will be part of the answer, but probably not all of the answer.

I was especially perplexed by the presentation saying that short hospice stays appear to arise from the difficulty of making prognoses, beneficiaries unwillingness to give up curative care, and the greater availability of non-toxic therapies. And then to go on to say that Medicare policy does not appear to be the cause, because all of those and two or three more are rooted in the particular Medicare policies that were put in place that started hospice.

There's nothing magic about hospice being turned on prognosis or requiring that you walk out on curative care. Hospice could have been more comprehensive. Hospice could have turned on severity of illness rather than prognosis. There are a number of ways in which the way that hospice is now behaving in the care system is predictable from Medicare policy. The fact that the average hospice duration of stay now is less than 20 days and only 20 percent of Medicare beneficiaries get to use it would tend to imply that in the two to three years people spend dying of their fatal illnesses now, and that 83 percent of all death in the U.S. is now in Medicare, would tend to imply that

there's a huge gap being left between hospice and all of end-of-life care that is not yet being addressed.

Hospice it seems as a program could expand to cover much of that, but can't because of the policies. Hospice cannot -- it could expand a little bit but they can't expand substantially to cover that population and by constrained by the prognostication. The prognostication data that was quoted is not the only prognostication data available. There is pretty good evidence to show that within a week of dying the average person still has a prognosis too good to go into hospice. Yet they're terribly sick and they're terribly disabled. You just don't know exactly when they're going to die.

So if we mean to have end-of-life care be more comprehensive and reasonable, then we're going to have to figure out a way to evade the prognostication requirement itself. The same issue arises with the others, but I won't take the time at the moment.

I would call on you not to just take these recommendations per se, but to call on yourselves or to call on the Congress to ask you to look at the more substantial problems of not just whether hospices can stay afloat and continue to enroll patients, but whether Medicare beneficiaries can ordinarily expect good comprehensive services at the end of life, and what Medicare policies get in the way of that. That I think would be a terribly fertile inquiry.

MR. WOODRUFF: I'm Roy Woodruff, and I'm the executive director of the American Association of pastoral counselors, and a long time certified and practicing pastoral counselor. I have been with you all afternoon and understand you're tired, and also have a deeper understanding of the difficulty and complexity of your task and commend you for your effort.

In listening to your discussion of the non-practicing practitioners and inclusion as providers in Medicare it was apparent that there were a number of errors of fact and of assumption in regard to pastoral counselors that I wanted to very briefly speak to.

One of those that I need to clarify is in relation to our name. What you have before you is called pastoral care counselors. That is not the term we use and not how we refer to ourselves. Somehow when the mandate from Congress came to you to consider pastoral counselors along with our collegial groups of other non-medical practitioners it came in the form of pastoral care counselors. That's the first time we've ever seen that. But the time we saw it, we were told it was too late to change that in the process.

But it's a significant term because that can be very confusing. Pastoral care is a general caring function of clergy in general, of all faith groups. So that gives rise to the question that was asked, if a priest is saying mass or giving the sacraments or a rabbi is teaching, would that be covered? That has nothing to do with what we're talking about. That might be pastoral care, but it's not pastoral counseling.

Pastoral counseling as we use it is a highly disciplined, highly focused, therapeutic process with persons seeking the assistance of pastoral counseling in significant problems of mental health, a relationship, or problems of living. So I don't

want you to confuse that with the general pastoral care work of pastors and clergy in general.

Another misconception I think I need to clear up is the distribution of pastoral counselors. It seemed to be assumed that we, like some other health professionals, are primarily in urban areas and not accessible in under-served areas. That is absolutely not the case.

When we break down our certified pastoral counselors into small town rural, mid-sized cities, and large urban areas there are more practicing in small town rural than either of the other two. So that is part of what led the Office of Personnel Management in the management of the Federal Employees Health Benefits Plans to, after about a year-long, very careful study of pastoral counselors, to mandate that certified pastoral counselors be included as providers in the 12 medically underserved states. Because they began to realize that our people are there and it would help the mental health care service in those states if pastoral counselors were recognized as providers.

So about a year and-a-half ago that happened and now OPM recognizes and encourages all health care plan providers in all states to include pastoral counselors as providers.

Part of where they got their information was from CHAMPUS TriCare where we have been providers for over 30 years and have a long and very positive history of utilization and positive experience. That was reported out to us by OPM so that when they looked at our history with CHAMPUS it was clear that we were valued in that and that we were seen as very qualified providers for mental health care.

Let me make another comment about qualifications. It also seemed to be assumed that somehow our members were not as qualified as some of the other similar professional groups and licensed groups. Again, that is not the case. Most of our members are in fact licensed, but our standards are very carefully and documentably equal or higher to counselor licensing standards and some other kinds of certifications.

I'll just use myself as an example. I have a Ph.D. in pastoral counseling. Most of our certified members do have doctoral level degrees in addition to a master's degree. I completed my Ph.D. in the minimal amount of time that's allowed for it, in six years after college. That's because it's built on a lot of other -- a broad basis of education.

MR. HACKBARTH: Mr. Woodruff, you're going to have to bring your comment to a close.

MR. WOODRUFF: I understand. I just wanted to correct these assumptions, and there are a few others that we would place in writing, and we do appreciate your consideration.

MS. McEWAN: Good afternoon, I'm Erin McEwan from the American Nurses Association. I first wanted to address the comment about nurses provide nursing care versus medicine. I can't speak to what the position of the association 10 years ago was, but I would suggest that today perhaps it is a bit more nuanced.

With that said, to dive right into something with full awareness of how unpopular it is going to be, I would suggest that the nurses' association believes that nurse practitioner

care services often are directly substitutable for specifically GP care. There's very good research done on this recently printed in the January issue of Health Affairs on physician substitutability for nurse practitioners and how outcome studies have shown that there is really no difference.

With that said, moving on to the first assist issue, given the tenor of the conversation today I really don't believe what I'm about to say makes that much of a difference but I feel the urge to say it regardless.

One of the differences that I think should be mentioned between nurse first assists and surgical techs is the perioperative. As registered nurses, nurse first assists do often provide all of the perioperative services, be that the pre-op education to the pre-op workup, to the actual services provided within the four walls of the OR, to the recovery room care, to post-op education. I am certainly not an expert on surgical techs, but I do not believe that that is something that they do as well.

Thank you.

MS. POWERS: Good afternoon. My name is Diane Powers. I've written to all of you last year about inclusion of master's level therapists as providers for Medicare. I have a LPC, licensed professional counselor. I'm also a licensed marriage and family therapist, and I'm also a certified rehabilitation therapist.

I have specialized skills in working with patients with Lou Gehrig's Disease and am the mental health expert on the website that represents them.

Prior to being a therapist, for 25 years I ran physician's group practices and a department at a major university. My undergraduate degree is in health care administration.

So I have approached mental health as I approached physical health, from an effective cost-containment, continuity of care approach. It is from that perspective that I would like to encourage you to take a second look at inclusion of LPCs, marriage and family therapists and pastoral counselors as mental health providers.

Today I have just gone to a seminar on depression. It was out in Virginia. The statistics are saying the incidence of depression in the elderly is as high as 60 percent. The attempted and completed suicides are equally high. The botched suicides are of every attempted suicide, maybe 10 percent are botched, or do not accomplish what the person intended. That results, many times, in being hospitalized for many years because of gunshot wounds that were less than terminal.

The statistics also said that most elderly who attempted suicide had seen their family physicians within a week of attempting suicide, but they had not focused on the mental health issue but actually the blood pressure and things of that sort.

Additionally, last year this board or Medicare powers that be included patients with Lou Gehrig's Disease as recipients of Medicare. A little bit of background, Lou Gehrig's Disease is a progressive neuromuscular breakdown in the movement area, not the sensing area in the movement area. Many people with Lou Gehrig's Disease would prefer to stay at home with their caretakers.

One of the issues that was raised a few moments ago was

about hospice care. Why is the length of time that hospice care is shorter than anticipated when the parameters say six months until death. And yet, many people with ALS will stay at home and only in the final week or month have hospice care come into their home.

I put before you the fact that good mental health counseling helps ALS people deal with their grief, recognizes depression in the elderly, also recognizes alcohol and substance abuse, medication, self-medication in the elderly.

MR. HACKBARTH: Excuse me, the points you're making are really critical ones. The reason you see people starting to get up and leave is we actually have another thing to do to at 6:30, so we are just about out of time her.

MS. POWERS: I will talk very quickly.

MR. HACKBARTH: 15 seconds worth. We have two other people.

MS. POWERS: In the area of mental health there is cross-referral. I refer to social workers, they refer to me. I have expertise in ALS, as well as other colleagues have expertise in geriatrics.

I believe that this is a necessary thing for Medicare clients to be able to receive. In the field right now, many psychiatrists and psychologists and social workers are withdrawing from participation in insurance. I believe this will have a tremendous impact on Medicare within the next six years when the baby boomers enter into coverage.

And so I ask you to be farsighted, rather than shortsighted, and include social workers, LPCs, marriage and family therapists, and family counselors in your Medicare mental health program.

Thank you.

MR. HACKBARTH: Thank you. You, regrettably, are at the end of the line but it is the end of the line.

AUDIENCE SPEAKER: I'll be very brief. I just specifically wanted to address the issue of access with respect to mental health services that was spoken about earlier.

One of the things I think is important to understand is that 57 percent of the U.S. population live in areas that the federal government has designated as mental health professional shortage areas. That is a practitioner to population ratio that the federal government has used.

There are five core mental health professionals that are used who are given equal weight within that designation: psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, and marriage and family therapists. So when the federal government seeks to determine whether or not we have an access problem, they calculate the availability of marriage and family therapists.

That creates a problem for the Medicare population in that it creates a false sense of access, because in those areas we believe we don't have an access problem, marriage and family therapists are not covered by the Medicare. But the government says we don't need to put any more mental health professionals there because we have an adequate supply.

There are access issues out there and I think there's significant data to substantiate that a lot of people in this country have difficulty access mental health services.

MR. MEYERS: Good evening, I'm Nick Meyers, Deputy Director for Federal Relations of the American Psychiatric Association. I'll be extremely brief.

We believe that there is an access problem in the Medicare program. There's an equity problem in the Medicare program. Unfortunately, our view is that the addition of additional non-physician and mental health practitioners will do nothing to address it.

The real access issue, the real equity issue, is Medicare's statutory discrimination against patients who seek treatment from mental disorders by requiring them to pay half the cost of their care out-of-pocket. We would urge this commission to make a strong recommendation to Congress that before it considers any other provider related issues under the Medicare program with respect to mental health services, it ought to address the existing structural discrimination against patients who seek treatment for mental disorders.

If you want to do one thing for patients, it is to say to those patients that all they have to pay for a trip to a psychiatrist, a psychologist, a social worker, or a family practitioner for a mental health visit is the same 20 percent copay that they would pay if they saw an endocrinologist for treatment of diabetes. Until that issue is addressed, access issues will continue. That is the real equity argument with respect to mental health services.

Thank you.